

BARIATRIC NUTRITIONAL ASSESSMENT

Please answer all questions as honestly as you can. You may leave blank any questions you do not feel comfortable answering. Write "N/A" for any question that does not apply to you.

GENERAL INFORMATION

Patient Name: _____

Family Physician: _____

Date of Birth: _____

Address: _____

State Age: _____

Insurance: _____

State Height: _____

Does Insurance reimburse for Nutrition

State Weight: _____

Therapy? _____

Surgeon and recommended surgery: Dr. Hung _____

Dr. Taddeucci _____

Lab-Band _____

Gastric Bypass _____

Gastric Sleeve _____

- Home Address : _____
- Email Address (for receiving Bariatric E-Newsletter) _____
- Home Telephone _____ Work Telephone _____ Cell Phone _____
- Occupation (if retired, note previous occupation) _____
- Employer _____
- Marital Status _____
- Who lives in your household? _____
- Do you have children? If yes, please list gender and age: _____
- Circle the last year of school attended, and degree if appropriate:
1 2 3 4 5 6 7 8 9 10 11 12 College 1 2 3 4 Master's Level Doctorate Other Education _____

WEIGHT HISTORY:

- Current weight _____ Height _____
- My highest adult weight _____ Date _____; My lowest adult weight _____ Date _____
- Desired highest weight _____
- Current clothing sizes: Dress or Suit _____ Blouse or Shirt _____ Skirt or Pants _____
- How often do you weigh yourself: _____
- How would you describe your current weight? _____
- How satisfied are you with the way you look at this weight? (circle one)
Completely Satisfied Satisfied Neutral Dissatisfied Very Dissatisfied
- At what weight have you felt your best, or do you *think* you would feel your best? _____
- How much weight would you like to lose? _____
- How does your weight affect your daily activities (getting dressed, working, etc.)? _____
- How do you think your life would change if you could reach your weight goal? _____

- Why do you want to lose weight at this time? _____

13. What are the attitudes of the following people about your attempt(s) to lose weight?

	Negative	Indifferent	Positive
Spouse			
Children			
Parents			
Employer			
Friends			

10. Do these attitudes affect your weight loss or gain? Yes No

If yes, please describe: _____

11. At what age did you start your first diet? _____

12. Who or what gave you the idea to start dieting? _____

13. Who wanted you to lose weight and why? _____

14. How did you decide to seek surgery as a way to control your weight? _____

15. Who will help you with meals, transportation, errands, etc. after your surgery? _____

16. How often do you use any of the following substances?

Habit	Daily	Weekly	Monthly	Previously	Never
Cigarettes					
Regular Coffee or Tea					
Caffeine Soda Pop					
Alcohol					
Marijuana					
Tranquilizers					
Barbituates/Sleeping Pills					
Amphetamines					

17. A number of different ways of losing weight are listed below.

Please indicate any methods you have used by filling the appropriate blanks.

In the Comments, list any significant life events you feel were related to either your weight gain or loss (i.e. prom, dating, weddings, pregnancies, illness, accidents, deaths, reunions, sports).

COMMERCIAL DIETS	Age	How Long	Pounds Lost or Gained	Comments
<input type="checkbox"/> Weight Watchers				
<input type="checkbox"/> TOPS (Take Off Pounds Sensibly)				
<input type="checkbox"/> Jenny Craig				
<input type="checkbox"/> OA – Overeaters Anonymous				
<input type="checkbox"/> NutriSystem				
<input type="checkbox"/> OptiFast				
<input type="checkbox"/> SlimFast				
<input type="checkbox"/> Diet Books:				
FAD DIETS				
<input type="checkbox"/> Cabbage Soup Diet				
<input type="checkbox"/> High protein, low carbohydrate (such as Adkins, South Beach, Sugar-Busters, Protein Power, Suzanne Sommers, Richard Simmons,)				
<input type="checkbox"/> High carbohydrate, low fat				
<input type="checkbox"/> Starvation - Fasting				
<input type="checkbox"/> Body Wraps				
PRESCRIPTION/DIET PILLS				
<input type="checkbox"/> Redux (dexfenfluramine)				
<input type="checkbox"/> Pondimin (fenfluramine)				
<input type="checkbox"/> Fen/Phen				
<input type="checkbox"/> Phentermine/Fastin/Adipex				
<input type="checkbox"/> Meridia				
<input type="checkbox"/> Xenical				
<input type="checkbox"/> Dexatrim				
<input type="checkbox"/> Ephedram, Ma Haung				
<input type="checkbox"/> Metabolite				
<input type="checkbox"/> Acutrim				
<input type="checkbox"/> Dexatrim				
THERAPY/OTHER PROGRAMS				
<input type="checkbox"/> Physician-supervised diet				
<input type="checkbox"/> Registered Dietitian				
<input type="checkbox"/> PsychoTherapy				
<input type="checkbox"/> Hypnosis				
<input type="checkbox"/> Exercise Programs				
<input type="checkbox"/> Hypnosis				
<input type="checkbox"/> Surgery: (liposuction, gastric bypass, wired jaws, etc.)				
<input type="checkbox"/> Your own system: Describe:				

18. What is the reason (s) you usually go off a diet? _____

19. Have you ever used vomiting as a means of weight control? Yes No
If yes, when and why did you start vomiting to control your weight? _____

20. Have you ever experienced periods in which you eat uncontrollably (binge)? Yes No
If yes, when and why did it happen _____

21. Do you ever make yourself vomit after overeating? Yes No

22. Have you ever taken laxatives as a means of weight control? Yes No
 If yes, which laxatives? _____
 How often? _____ Age you began? _____
 Who or what gave you the idea to start using laxatives to control your weight? _____
23. Have you ever used enema's or diuretic's as a means of controlling weight? Yes No
 If yes, at what age, and how often? _____
24. Indicate any mood changes you have noticed while on a diet, or after a significant weight loss or gain:

EXERCISE HISTORY

1. How physically active are you? (circle one)
 Very Active Active Average Inactive Very Inactive Other _____

2. Do you do any of the following exercises?

Activity	Number of Times/Week	How Long
<input type="checkbox"/> Walking		
<input type="checkbox"/> Bicycling		
<input type="checkbox"/> Swimming/Water exercises		
<input type="checkbox"/> Golf – walking or cart		
<input type="checkbox"/> Tennis		
<input type="checkbox"/> Aerobics		
<input type="checkbox"/> Weight training		

3. Is there anything that prevents you from being physically active? _____
4. How often do you play? _____
5. What do you like to do for fun? _____
6. Are you committed to incorporating physical activity into a long-term weight management program? Yes No
7. **Do you take vitamin, mineral, or nutritional supplements? *** Yes No
 If yes, which ones, and how much? _____

*** PLEASE BRING THESE WITH YOU ON YOUR FIRST VISIT TO THE DIETITIAN.**

1. Are you allergic to any medications or drugs? Yes No. If yes, please list below:

2. Psychological Therapy History:
 Have never been in therapy Currently in therapy: Individual Group
 Name of therapist _____
 Working on _____
 Not currently in therapy, but have been in the past. Individual Group
 Name of therapist _____
 Presenting problem _____
 Why did you stop? _____
3. Have you ever taken any medications or herbs that affect your emotional/mental state? Yes No
 If yes, list which ones: _____

EATING HABITS

1. What speed do you normally eat? (circle) Quickly Moderately Slowly
2. Do you think you chew your food thoroughly? Yes No Sometimes
3. Do you have any food intolerances, Food Allergies or special diet needs that you follow now? Yes No
If yes, please list: _____
4. Are there foods that you dislike and refuse to eat? _____

5. What your favorite foods? _____
6. Have you read about food and beverage guidelines you will need to follow after your surgery? Yes No
7. Do you know how to measure foods and beverages accurately? Yes No
8. Do you understand how to read food labels? Yes No
9. Do you understand the consequences of not complying with the food guidelines after surgery? Yes No
10. Do you understand the long-term changes in food intake that will be necessary for all occasions after surgery for the rest of your life? Yes No
11. How do you decide what foods to eat? _____
12. How do you decide when to eat? _____
13. How do you decide how much to eat? _____
14. How do you decide when to stop eating? _____
15. Can you tell when you are physically hungry? Yes No
16. Do you know if you are eating or drinking for reasons other than hunger or thirst? Yes No
17. Can you tell the difference between hunger and thirst? Yes No
18. Do you like to drink water? Yes No
19. Can you tell when you are physically satisfied with the amount of food you have eaten? Yes No
20. Can you tell when your stomach is "full"? Yes No
21. Can you tell when your stomach is "stuffed"? Yes No
22. **If you could have any three wishes, what would they be?**
Wish 1: _____
Wish 2: _____
Wish 3: _____
23. How do you think the procedure will affect your life? _____

24. What advantages do you see for having the procedure? _____

What disadvantages do you see for having the procedure? _____
25. Please list any questions you want to be sure we discuss during your appointment:

26. Please add any other information that you feel may be relevant:

